No. 99-1815 (6)

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IN THE

Supreme Court of the United States

NATIONAL LABOR RELATIONS BOARD,
Petitioner,

v.

KENTUCKY RIVER COMMUNICTY CARE INC., *et al.*,
Respondent.

KENTUCKY STATE DISTRICT COUNCIL OF CARPENTERS, AFL-CIO,
Respondent/Intervenor.

On Writ of Certiorari to the United States Court of Appeals for the Sixth Circuit

MOTION FOR LEAVE TO FILE BRIEF *AMICUS CURIAE* AND BRIEF OF SERVICE EMPLOYEES INTERNATIONAL UNION, AMERICAN FEDERATION OF TEACHERS, AMERICAN FEDERATION OF STATE, COUNTY AND MUNICIPAL EMPLOYEES, AND UNITED FOOD AND COMMERCIAL WORKERS AS *AMICUS CURIAE* IN SUPPORT OF PETITIONER

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MOTION FOR LEAVE TO FILE BRIEF *AMICUS CURIAE* OF SERVICE EMPLOYEES INTERNATIONAL UNION, AMERICAN FEDERATION OF TEACHERS, AMERICAN FEDERATION OF STATE, COUNTY AND MUNICIPAL EMPLOYEES, AND UNITED FOOD AND COMMERCIAL WORKERS AS *AMICUS CURIAE* IN SUPPORT OF PETITIONER

Pursuant to Supreme Court Rule 37(b), the Service Employees International Union (SEIU) respectfully moves

this Court for leave to file the accompanying brief *amicus curiae* in support of Petitioner National Labor Relation Board. The Solicitor General on behalf of the Board, and counsel for Respondent Kentucky State District Council of Carpenters, AFL-CIO, consent to the filing of this brief.[1] The consent of the attorney for Respondent Kentucky River Community Care, Inc. was requested but refused.

INTEREST OF THE AMICUS CURIAE

The Service Employees International Union (SEIU), the American Federation of Teachers (AFT), the American Federation of State, County and Municipal Employees (AFSCME) and the United Food and Commerical Workers (UFCW) (jointly referenced hereafter as "Unions") are international labor organizations that jointly represent a substantial number of nurses working in hospitals and residential care facilities in the United States. The question this amicus brief addresses is whether the National Labor Relations Board reasonably determined that the term "supervisor" under Section 2(11) of the National Labor Relations Act, 29 U.S.C. § 152(11), does not encompass nurses who direct and assign work to other nursing staff in accordance with employer-specified standards, regulatory requirements and routine professional judgement.[2]

While the instant case focuses on six registered nurses working in a residential psychiatric facility, the question presented has broad implications within the nursing community. The Court's answer to this question portends to directly affect nurses who work in similarly situated residential and long-term care facilities. If the Court of Appeals' decision stands, a substantial percentage of nurses represented by the Unions will be at risk of losing the protections of the Act.

The Unions have prepared this amicus brief mindful of this Court's admonition that it should address relevant matter not already addressed by the parties. This brief accordingly seeks to inform the Court's consideration of the question presented by providing a fuller picture of what nurses do and the conditions under which they are employed when working in nursing homes and similar long-term care facilities, by referencing empirical studies, industry journals and applicable healthcare regulations.

Respectfully submitted,

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[1] These letters of consent have been filed with the Clerk of this Court.

[2] We limit ourselves to this question (the first presented by the Board's Petition), and defer to the Board, whose position we fully support, to address the remaining two questions presented.

BRIEF OF SERVICE EMPLOYEES INTERNATIONAL UNION, AMERICAN FEDERATION OF TEACHERS, AMERICAN FEDERATION OF STATE, COUNTY AND MUNICIPAL EMPLOYEES, AND UNITED FOOD AND COMMERCIAL WORKERS AS AMICUS CURIAE IN SUPPORT OF PETITIONER

This *amicus curiae* brief is filed pursuant to Supreme Court Rule 37(b).[1]

INTEREST OF THE AMICUS CURIAE

The Service Employees International Union, AFL-CIO ("SEIU") is an international labor organization with a membership of 1.4 million working men and women. Approximately 710,000 SEIU members are healthcare workers—a number that includes 115,000 nurses—employed in hospitals, nursing homes, and other residential care facilities throughout the United States.

The American Federation of Teachers, AFL-CIO ("AFT") is an international labor organization that represents over 1.1 million members who work in public elementary and secondary schools, community colleges and universities, state government and health care. AFT has a significant and long-standing interest in the issues raised in this case concerning nurses and other health care employees.

The American Federation of State, County, and Municipal Employees, AFL-CIO ("AFSCME") is a labor organization representing approximately 1.5 million working men and

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[1] Counsel for a party did not author this brief in whole or part and no person or entity other than *amicus curiae* contributed monetarily to the preparation or submission of this brief.

women throughout the United States, Puerto Rico, and Panama. AFSCME is the voice for approximately 360,000 health care employees, 76,000 of whom are nurses. Throughout the country, AFSCME develops, initiates, assists, and defends litigation in state and federal courts as well as before administrative agencies addressing questions of workers' rights.

The United Food and Commercial Workers International Union, AFL-CIO, CLC ("UFCW") is a labor organization of 1.4 million members, representing workers across the United States in the meat packing and other food processing, supermarket and other retail, nursing home, hospital, and other healthcare, and insurance industries. The UFCW believes that the National Labor Relations Act (NLRA) should be construed broadly in order to protect the employee status, with its concomitant rights, of workers who perform hands-on, prescribed duties and are in no practical sense employer surrogates. The UFCW is therefore deeply concerned that the NLRA definition of employee not be artificially interpreted so that workers forfeit federal labor rights.

SUMMARY OF ARGUMENT

As of the latest figures, there are approximately 333,500 nurses working in the nursing home industry. The majority are employed as staff nurses, providing direct, hands-on care to nursing home residents. They are responsible for performing a wide range of nursing care activities from updating records, to performing medical procedures and inserting intravenous lines, to dispensing medications, to giving therapeutic massages, to assisting with basic daily living functions such as eating and dressing. The work these nurses do is low-paid and stressful. Their workplace also has one of the highest injury and illness rates in the nation. As a result, there are chronic staff shortages and a high turnover

among staff nurses. This, in turn, significantly impacts patient care.

To exclude staff nurses from the protections of the National Labor Relations Act, which affirmance of the decision below would do, would contravene Congress' intent as described in this Court's decision in *Beth Israel Hospital v. NLRB*, 437 U.S. 483 (1978). Thus, Congress in enacting the 1974 health care amendments to the Act, and extending the protections of the Act to healthcare workers generally, expressly recognized that "wages were low and working conditions poor in the health-care industry, . . . that as a result, employee morale was low and employment turnover high" and that "the extension of organizational and collective bargaining rights would ameliorate these conditions and elevate the standard of patient care." *Id.* at 497-98. These are precisely the conditions that exist for staff nurses in nursing homes. For this reason, this Court should carefully scrutinize the Sixth Circuit's decision which threatens to sweep *all* such nurses outside the protections of the Act.

ARGUMENT

A. INTRODUCTION

This case presents the question of whether the term "supervisor" in Section 2(11) of the National Labor Relations Act, 29 U.S. C. § 151(11), encompasses nurses who direct or assign work to less-skilled nursing staff. While the instant case focuses on six registered nurses ("RNs") working in a residential psychiatric facility, the issue resonates broadly within the nursing community. A decision here is likely to impact nurses who work not only in psychiatric facilities but also in nursing homes and other residential care facilities.

In this regard, we note that the vast majority of the cases that have reached the Circuit Courts on the supervisory status of nurses have involved licensed practical nurses ("LPNs")

working in nursing homes.[2] And, while the instant case involves registered nurses (RNs), the Sixth Circuit, which decided the case presently before the Court, has denied enforcement of NLRB orders in *every single case* involving nursing home nurses that has come before it since this Court's decision in *NLRB v. Health Care & Retirement Corp.*, 511 U.S. 571 (1994), ruling each time that the nurses at issue—whether RNs, LPNs or both—are supervisors who fall outside the protection of the National Labor Relations Act. The type of limited authority to assign and direct that the Sixth Circuit finds sufficient to render the RNs to be supervisors in this case is the same as that exercised in typical nursing homes by staff nurses, both RNs and LPNs, with respect to nurse aides. The result, in the words of one Sixth Circuit jurist, is that "as a practical matter, we have made it impossible for nurses to form collective bargaining units in nursing homes." *Integrated Health Services v. NLRB*, 191 F.3d at 713 (J. Jones concurring).[3]

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[2] *See* e.g. *Beverly Enterprises v. NLRB*, 129 F.3d 1269 (D.C.Cir. 1997); *NLRB v. Hilliard Dev. Corp.*, 187 F.3d 133 (1st Cir. 1999); *Schnurmacher Nursing Home v. NLRB*, 214 F.3d 260 (2d Cir. 2000); *NLRB v. Attleboro Assoc.*, 176 F.3d 154 (3d Cir. 1999); *Beverly Enterprises v. NLRB*, 165 F.3d 290 (4th Cir. 1999); *Beverly Enterprises v. NLRB*, 165 F.3d 307 (4th Cir. 1999)(en banc); *Integrated Health Services v. NLRB*, 191 F.3d 703 (6th Cir. 1999); *Mid-America Care Foundation v. NLRB*, 148 F.3d 638 (6th Cir. 1998); *Grancare, Inc. v. NLRB*, 137 F.3d 372 (6th Cir. 1998)(en banc); *Caremore v. NLRB*, 129 F.3d 365 (6th Cir. 1997); *NLRB v. Grancare, Inc.*, 170 F.3d 662 (7th Cir. 1999); *Beverly Enterprises v. NLRB*, 148 F.3d 1042 (8th Cir. 1998); *Northern Montana Health Care Ctr v. NLRB*, 178 F.3d 1089 (9th Cir. 1999).

[3] *See Manor West, Inc. v. NLRB*, 60 F.3d 1195 (6th Cir. 1995); *Caremore v. NLRB*, 129 F.3d 365 (6th Cir. 1997); *Grancare, Inc. v. NLRB*, 137 F.3d 372 (6th Cir. 1998); *MidAmerica Care Foundation v. NLRB*, 148 F.3d 638 (6th Cir. 1998); *Edgewood Nursing Center v. NLRB*, 142 F.3d 433 (Table), 1998 U.S. App. LEXIS 3151 (6th Cir. 1998)(unpublished); *NLRB v. Grancare, Inc.*, 170 F.3d 662 (7th Cir. 1999); *Beverly Health & Rehabilitation Services, Inc., v. NLRB*, 181 F.3d 99, 1999 U.S. App. LEXIS 8395 (6th Cir. 1999) *(unpublished); Rehabilitation & Healthcare Center, Inc., v.* NLRB, 178 F.3d 1296 (Table), 1999 U.S. App. LEXIS 5878 (6th Cir. 1999)(unpublished). *See also Beverly California v. NLRB*, 970 F.2d 1548 (6th Cir. 1992); *NLRB v. Beacon Light Christian Nursing Home*, 825 F.2d 1076 (6th Cir. 1987).

The briefs of the parties to this case necessarily will focus on the RNs at issue here. In addition, it is our understanding that the American Nurses Association is filing a brief as amicus curiae that addresses the situation of RNs generally. In order to provide the Court with a more complete picture of the residential care nurses at issue in the majority of decided cases, and to avoid burdening the Court with a repetitious presentation of materials covered in other briefs, this brief focuses on the situation of LPNs in residential long-term care facilities.

B. THE ROLE OF STAFF NURSES IN NURSING HOMES

1. General Demographics

There are approximately 17,000 nursing homes in the United States, which range in size from small facilities with fewer than 50 beds to larger ones with over 200 beds. *HCFA, Rep. to Congress: Appropriateness of Minimum Staffing Ratios in Nursing Homes*, 2-1, (Summer 2000) (hereafter referenced as *"HCFA Report"*); C. Gabrel, *An Overview of Nursing Home Facilities: Data from the 1997 National Nursing Home Survey*, in *Advance Data from Vital and Health Statistics (National Center for Health Statistics, DHHS Pub. No. (PHS) 2000-1250, No. 311, 2000)*, (hereafter *"1997 National Nursing Home Survey"*). Most nursing home facilities are "private, profit-making organizations that are increasingly part of multi-organizational systems and investor-owned corporations." C. Harrington, *Nursing Facility Quality, Staffing, and Economic Issues, in* Institute of

Medicine, *Nursing Staff in Hospitals and Nursing Homes: Is It Adequate*? 493 (Academy Press 1996) [latter hereafter referenced as "*IOM Study*"].[4]

Under federal law, each nursing home must have at least one licensed nurse on duty 24 hours a day. 42 U.S.C. §1396r(b)(4)(c); 42 CFR §483.30. As of the latest studies, there are approximately 333,500 nurses working in the nursing home industry, a figure that includes both RNs and LPNs. *1997 National Nursing Home Survey* at 8. In general, the majority of staff nurses in nursing homes are LPNs. *Id.* RNs who serve as staff nurses in nursing homes, however, generally work interchangeably with LPNs. *HCFA Study* at 5-30 to 5-31 and App. B3. *See Mid-America Care Foundation v. NLRB*, 148 F.3d 638, 639 (6th Cir. 1998)(noting that from employer's perspective "there appears to be no distinction between the duties of registered nurses and LPNs; most internal documents refer to registered nurses and LPNs interchangeably as "nurses.")

LPN training generally consists of a one-year program administered through a technical or vocational school. *IOM Study* at 76-77; BLS, *Occupational Outlook Handbook* 227 (BLS 2000-01) {www.bls.gov}.[5] LPNs are trained in basic

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[4] In 1994, Congress directed the Secretary of the Department of Health and Human Services to ask the Institute of Medicine ("IOM") of the National Academy of Sciences to undertake a study to determine whether and to what extent there is a need to increase the number of nurses in hospitals and nursing homes to promote the quality of patient care. The IOM Study is the report issued by the committee of experts appointed to research this issue. Appended to the Report are the statistical resources and the background papers commissioned by the committee.

[5] RNs working in nursing homes generally have two-year associate college degrees. *IOM Study* at 78; Maas et al., *Nurse Staff and Quality of Care in Nursing Homes, in IOM Study* at 396-97.

nursing concepts and patient care related subjects in order to perform basic bedside care. BLS, *Occupational Classification System Manual* {www.bls.gov}. Over 95% of LPNs are women and over 16% are African American. D. Himmelstein and S. Woolhandler, *Medical Care and Employment in the United States, 1968 to 1993, in Health Policy: Crisis and Reform in the U.S. Health Care Delivery System*, 182 (Harrington and Estes, eds., 3d ed. 2001). A majority of newly licensed LPNs begin their careers in long-term care facilities. *IOM Study* at 78.

2. Staff Nurses in Nursing Homes are Direct Care Providers

Nursing care is not limited to handing out medicines and taking temperatures, but covers the entire spectrum of care from assessing resident health status and updating records to providing wound care, performing medical treatments and monitoring intravenous procedures, to meeting the residents' basic physical needs such as assisting with bathing and eating, emptying bedpans, providing emotional support, and giving massages. In the words of a widely respected nurse advocate, each of these aspects of nursing, weaves "a tapestry of care, knowledge, relationship and trust that is critical to patients' survival." S. Gordon, *Life Support: Three Nurses in the Front Lines* 12, 17 (Little, Brown & Co. 1997).

As reflected in a leading treatise on nursing home administration, nursing staff is tasked with:

- providing nursing care to patients/residents as ordered by the physician
- completing the Minimum Data Set, any required protocols triggered by the Minimum Data Set, creating and implementing and updating the comprehensive plan of care
- administering medications to the patients/residents
- keeping patient records

- monitoring patients/residents for changes in condition and notifying the responsible physician—in short, serving as the physician's eyes and ears on a 24-hour basis
- achieving optimal quality of care and quality of life for patients/residents
- making certain that every patient/resident is functioning at the highest possible level
- playing a coordinating role with other staff (e.g. ensuring that planned physical therapy, activities, physician office visits and the like take place)

J. Allen, *Nursing Home Administration*, (3d ed. 1997). This accords with the description of standard LPN duties found in the BLS Occupational Handbook:

> They take vital signs such as temperature, blood pressure, pulse, and respiration. They also treat bedsores, prepare and give injections and enemas, apply dressings, give alcoholic rubs and massages, apply ice packs and hot water bottles, and insert catheters. LPNs observe patients and report adverse reactions to medications or treatments. They collect samples from patients for testing, perform routine laboratory tests, feed them, and record food and liquid intake and output. They help patients with bathing, dressing, and personal hygiene, keep them comfortable, and care for their emotional needs . . . .

BLS Occupational Outlook Handboook, supra at 227.

A review of the case law confirms this portrayal as typical of staff nurses' duties in nursing homes. Thus, the courts have been in general agreement with the observation that:

> [the] LPNs' duties primarily relate to direct patient care including: dispensing medication, performing supplemental feedings, assisting regular feedings, checking room conditions, ensuring that residents are clean, dry, and regularly turned, charting vital signs, noting residents' intake and output, and reporting patient conditions at the end of the shift.

Glenmark Assoc. v. NLRB, 147 F.3d 333, 336 (4th Cir. 1998). *Accord*: *Schnurmacher Nursing Home v. NLRB*, 214 F.3d at 263 (nurses are "responsible for providing necessary patient care, including the administration of medicine and medical treatments, bathing, dressing, grooming, and other assistance with daily living."); *NLRB v. Hilliard Dev. Corp.*, 187 F.3d at 138 (nurses "provide both nursing care and general assistance with residents' daily activities."); *Beverly Enterprises v. NLRB* 165 F.3d at 302 n. 4 (Phillips, J., dissenting) (nurses "spend the vast majority of their time on duty doing exactly what the [assistants] do—directly attending to patients' basic medical and personal hygiene needs"); *Beverly Enterprises v. NLRB* 129 F.3d at 1270 ("LPNs pass medication, perform treatments on patients, stock the medical supply cart, complete paperwork and patient assessments, and accompany doctors on rounds"); *Rest Haven Living Ctr., Inc.*, 322 N.L.R.B. 210, 153 L.R.R.M. 1132, 1133 (1996) ("approximately 90 percent of [the nurse's] job consisted of caring for the residents of the nursing home").

Indeed, even the Sixth Circuit acknowledges that providing direct care is the principal duty of staff nurses in nursing homes. *See* e.g. *Caremore, Inc. v. NLRB*, 129 F.3d at 367 (nurses "spent the majority of their time on direct patient care."); *Beverly Health & Rehabilitation Service, Inc. v. NLRB*, 1999 U.S. App. LEXIS 8395 at *3 (nurses "spend the majority of their working time on direct patient care…[they] make rounds of the residents in their assigned wings and perform patient assessments, dispense medications, provide treatments, take vital signs, and observe any changes in the residents' medical status."); *Edgewood Nursing Ctr., Inc. v.*

NLRB, 1998 U.S. App. LEXIS 3151 at *5 (nurses "spent a substantial amount of work time performing 'hands on' resident care").

3. Staff Scheduling in Nursing Homes.

Every nursing home receiving federal Medicare or state Medicaid funds is required by law to have a RN on staff who serves as a full-time Director of Nursing ("DON"). 42 CFR § 483.30. DONs generally have the principal responsibility for making staffing and scheduling decisions. As noted in the HCFA report (at 5-24):

> The staffing process is directed primarily by the DON, the ADON [assistant DON], or the scheduler, whose responsibilities usually include supervising the staffing process, allocating staff, or adjusting staffing. Input by other nursing staff is generally limited, and made only in terms of requesting vacation or leave. Eight out of ten facilities interviewed use a scheduler (also called the Staffing Coordinator). The Staffing Coordinator could be the DON who is ultimately responsible for the scheduling process. In about half of the facilities, the scheduler is responsible for scheduling both licensed and unlicensed staff. In the other facilities, the DON is responsible for scheduling the licensed staff (RNs, LPNs) while the scheduler is responsible for unlicensed staff (nurse aides).

And, to the extent that the DON delegates these scheduling tasks, the HCFA report also makes it clear that such duties are clerical or ministerial in nature:

> Oftentimes, the scheduler position is a clerical staff position located within the administrative offices, and the scheduler assists with payroll or other administrative tasks as time permits. Across the facilities, schedulers work between 16 and 40 hours per week on staffing related activities. The scheduler is usually responsible for receiving call-outs and filling vacancies as needed. To fill vacancies, facility staff are usually the first to be contacted (i.e. overtime for staff) and agency staff are used as a last resort. Facilities prefer to use per diem staff (regular staff) rather than agency staff to fill vacancies, but per diem staff usually are not available.

HCFA Report at 5-25. Staff scheduling systems typically employ weekly or bi-weekly master schedules, which take into account "resident census, informal measures of resident acuity, shift, and consideration for a State-mandated minimum staffing standard." *HCFA Report* at 5-24.[6]

In 1997, most nursing homes had a FTE nursing staff ratio of 8.8 RNs, 11.9 LPNs and 38.3 nurse aides per 100 residents. *HCFA Report* at 3-14, n.24. *See also 1997 National Nursing Home Survey* at 3, 8. A more recent study indicates that in 1998, the average number of nursing staff hours per resident day was: .6 for RNs, .6 for LPNs and 2 for aides. C. Harrington, H. Carrillo, S. Thollaug, P. Summers and V. Wellin, *Nursing Facilities, Staffing, Residents and Facility Deficiencies, 1992 Through 1998*, 55 Gerontology (Sept. 2000), *also in* M. Dellefield, *The Relationship Between Nurse Staffing in Nursing Homes and Quality Indicators: A Literature Review*, *J. of Gerontology* 14, 18 (June 2000). This ratio of 1.2 nurses[7] to 2 aides parallels the ratios reflected in the cases that have come before the Courts of Appeals. *See, e.g., Integrated Health Services v. NLRB*, 191 F.3d at 713 (40 nurses: 40-50 aides); *NLRB v. Hilliard Dev. Corp.*, 187 F.3d at 148 (17 nurses: 30 aides); *GranCare, Inc. v. NLRB*, 170 F.3d at 667 (59 nurses:90 aides); *Beverly*

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[6] Thirty-seven states mandate minimum staffing ratios for nursing homes. Some of these are premised on hours of nursing care per resident per day while others use the ratio of staff members to residents. *HCFA Report* at 2-19 to 20.

[7] Excluding DONs and Assistant DONs.

Enterprises v. NLRB, 148 F.3d at 1047-48 (18 nurses: 28 aides).

In light of the above, it is apparent that classifying all RNs and LPNs working in nursing homes as supervisors—as the Sixth Circuit and other Circuits have done—creates an unreasonable ratio of supervisors to supervised. *See, e.g.*, *Beverly Enterprises v. NLRB*, 165 F.3d at 302 (10 supervisors: 21 employees); *Beverly Enterprises v. NLRB*, 165 F.3d at 309 (30 supervisors: 50-60 employees); *Glenmark Assoc. v. NLRB*, 147 F.3d at 335 (26 supervisors: 58 employees). While the Act does not include the ratio of supervisors to supervised among the criteria for assessing statutory supervisor status, as the Seventh Circuit aptly observed, a "highly improbable ratio of bosses to drones 'raises a warning flag.'" *NLRB v. GranCare*, 170 F.3d at 667, quoting *NLRB v. American Med. Services, Inc.*, 705 F.2d 1427, 1473 (7th Cir. 1983).[8]

In the instant case, for example, if the RNs are deemed to be supervisors based on their routine direction of LPNs (which, as noted, parallels the routine direction of aides by RNs and LPNs in nursing homes) the ratio will be seven nurse-supervisors (i.e. the Nurse Coordinator and the six RNs) to three nurse-employees. If the Sixth Circuit's analysis is adopted, the result using the nationwide ratios of 1.2 nurses to 2 aides, will be to exempt almost 40% of patient care staff working in nursing homes from the protections of the Act. *NLRB v. GranCare*, 170 F.3d at 667.

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[8] In nursing home cases, the Board has found a 1:2 ratio of supervisors to supervised to be "an unusually high ratio." *National G. South, Inc.*, 230 NLRB 976, 979 (1977). Even a lesser ratio of one supervisor to three employees is an "unrealistic and excessively high ratio." *Airkaman, Inc.*, 230 NLRB 924, 926 (1977). *See* also *Beverly Enterprises*, 148 F.3d at 1047.

4. Staff Nurses are Poorly Compensated and Work Under Difficult Conditions

"Unfortunately, caring for the elderly is still not considered prestigious or financially rewarding when compared to other areas of nursing practice." Maas, *Nursing Staff and Quality of Care , supra*, at 369. As a result, the wages and benefits of nursing personnel in nursing homes traditionally have been "scandalously low." C. Harrington, *Wages & Benefits of Nursing Personnel in Nursing Homes*, 8 *Nursing Economics* 378 (1990). *See* also C. Harrington, *Nursing Facility Quality, Staffing and Economic Issues, supra* at 466.

In 1999, LPN wages in nursing homes averaged $13 per hour or about $27,000 a year. S. Adler, *Contemporary's 1999 Nursing and Administrative Salary Survey, Contemporary Long Term Care,* {www.cltcmag.com.}; *BLS Occupational Outlook Handbook, supra*, at 228. Moreover, most nursing home facilities do not provide health benefits for staff. *IOM Study* at 160; Harrington, *Nursing Facility Quality, Staffing and Economic Issues, supra* at 466.

Meanwhile, these staff nurses work in an industry that is ranked as one of the highest for employee injury and illness rates. The overall rate of injury and illness in nursing and personal care facilities between 1995 and 1998 (the latest year for which data was available) ranged from 18.2 to 14.2 per 100 full-time workers, as compared with the average private industry rate of 8.1 to 6.7 during that same period. BLS, *Occupational Injuries and Illnesses: Industry Data (1989-current)* {www.bls.gov.} Put in further perspective, the injury and illness rate among nursing home staff is higher than that in coal mining (9.1–8.2), construction (10.6–8.8), manufacturing (11.6–9.7), transportation (9.1–7.3), auto repair (6.6–5.1), hospitals (10.1–9.2) and, even, professional sports (16.1–12.4) *Id. See also, Workplace Injuries and Illnesses in 1997*, BLS New Release, Dec. 17, 1998. While

the rate of occupational injury and illness in private industry as a whole has remained constant or declined slightly since 1980, the rate for nursing homes has increased by over 60%. *IOM Study* at 170.

"[O]verexertion, being struck by an object, and falls to the same level are the leading ways in which workers are hurt on the job....Workers in nursing and personal care facilities had the highest rate of injuries among all private industries due to overexertion or falling to the same level (BLS, 1995b)." *IOM Study* at 170-71. Nursing staff in nursing homes "by the very nature of their work" are also "particularly vulnerable to the hazards of back injuries and associated pain." *Id.* at 173. Indeed, the BLS handbook openly warns that:

> L.P.N.s may face hazards from caustic chemicals, radiation, and infectious diseases such as hepatitis. They are subject to back injuries when moving patients and shock from electrical equipment. They often must deal with the stress of heavy workloads. In addition, the patients they care for may be confused, irrational, agitated, or uncooperative.

BLS Occupational Outlook Occupational Handbook at 227. Accord: *IOM Study* at 173-187 (noting that staff are particularly susceptible to back injuries, needlestick injuries, workplace related violence, physical aggression from residents, and work-related stress); B. Rogers, *Nursing Injury, Stress, and Nursing Care, in IOM Study* at 503-519 (same).

As one of the commissioned papers for the IOM Study further observed:

> Nursing home work is often difficult, stressful, frustrating and labor intensive. . . . Nursing home staff has to confront aging, disability, and dying. Much of the care of the elderly is not pleasant, such as caring for urinary and bowel incontinence or dealing with

> a cognitively impaired elder who is agitated and combative. Combined with low wages, minimal benefits, hard physical work, and often progressively deteriorating abilities of the residents, the nature of the work for nursing staff is often characterized as tedious, unpleasant, and unrewarding. Furthermore, because concern for costs is likely to continue while resident acuity increases, the workload for [aides] and nurses in nursing homes may very well get heavier.

Maas, *Nursing Staff and Quality of Care in Nursing Homes*, *supra* at 370.

Chronic staff shortages and high turnover are endemic in the industry, which only adds to the level of frustration and stress experienced by staff nurses. *HCFA Report* at 6-30; Harrington, *Wages & Benefits of Nursing Personnel in Nursing Homes*, *supra* at 379 (approximately 60% of nursing homes reported one or more vacancies for both RNs and LPNs). With fewer women going into this traditionally female-dominated workforce, this high vacancy rate can be expected to continue. Staiger *et al.*, *Expanding Career Opportunities for Women and the Declining Interest in Nursing as a Career*, 18 Nursing Economics 230-236 (noting that "only half as many women [are] entering nursing today as compared to 25 years ago.").

The combination of low wages, high stress, workplace injuries, and chronic understaffing, in turn, creates high turnover rates among nursing staff. The average turnover rate for RNs and LPNs working in nursing homes in 1994 was 56.3% and 52.5%, respectively. *IOM Study* at 160, Table 6.5; J. Johnson, M. Cowles, S. Simmens, *Quality of Care and Nursing Staff*, *IOM Study* at 430. Another study of nursing homes further found that the average tenure for RNs and LPNs was 1.5 years. *P. Stricklan, V. Einhorn,* C. Jones, *Characteristics of Nursing Staff in Long-Term Care*

Facilities: Their Training, Experience and Perceived Proficiency Levels, 36 *Nursing Homes* 22, 25 (Jan./Feb. 1987). *See also*, Harrington, *Nursing Facility Quality, Staffing and Economic Issues*, *supra*, at 466-67.

5. Working Conditions and Quality of Care

Nursing staff shortages in nursing homes impact not only the nursing staff but also the quality of care received by the residents. "High turnover rates and short employment periods for nursing staff, particularly in nursing homes are considered detrimental to patients and patient care." Stricklan, *Characteristics of Nursing Staff in Long-Term Care Facilities: Their Training, Experience and Perceived Proficiency Levels*, *supra* at 25. Turnover is "a major problem in continuity of care, which is an important factor in providing good care to residents with chronic conditions. Disruption of staff leads to residents having to constantly 'train' staff, problems in carrying through care plans, inaccurate assessments because of failure to be familiar with the baselines status of a resident, and failure of a facility to fully develop a philosophy of caring." J. Johnson, M. Cowles, S. Simmens, *Quality of Care and Nursing Staff in Nursing Homes, in Nursing Staff in Hospitals and Nursing Homes, IOM Study* at 430. The committee of experts appointed by the Institute of Medicine to investigate the issue similarly concluded that "[t]he preponderance of evidence from a number of studies using different types of quality measures has show a positive relationship between nursing staff levels and quality of nursing home care, indicating a strong need to increase the overall level of nursing staff in nursing homes." *IOM Study* at 153.

A telling reflection of what happens when there is a shortage of nursing staff was described in the HCFA Report. As one nursing home resident interviewed for the report explained: "[there is a] chronic staff shortage of nurses and

CNAs [i.e. certified nursing assistants]. [The] nurses have to help the CNAs and everyone does a job they aren't hired for." According to this same resident, with only one nurse available to administer medications, there were times when he got his medications up to a "couple of hours" late. *HCFA Report* at 4-19. At another facility described in the report "records showed that there was only one licensed nurse and one nurse aide on duty for the entire night shift to care for 41 and 45 residents, respectively." *Id.* at 4-23.

Wages, benefits, work hours, workplace health and safety protections, and staffing levels are all mandatory bargaining subjects which have been addressed beneficially in collective bargaining between employers and labor organizations for years. *See e.g.* D. Moniz, *Too Few Staff, Too Much Risk; Nurses in Facilities Lacking Staff Support*, 61 RN 63 (Dec. 1998) ("In the workplace, nursing unions have negotiated contacts that specify nurse-to-patient ratios and that allow members to actively participate in staffing decisions."); Gordon, *Life Support*, *supra* at 13 (noting that staff nurses and other health care workers under union contracts earn more than their non-union counterparts). Denying staff nurses the ability to exercise the NLRA's "fundamental right to organize and bargain collectively" is wholly unwarranted and can be expected to have wide-ranging consequences both for these dedicated and hardworking employees and for the broader public concerned with quality health care.

In *Beth Israel Hospital v. NLRB*, 437 U.S. 483, 497 (1978), this Court described Congress' intent in extending the protections of the Act to employees of health-care institutions. "Congress found that wages were low and working conditions poor in the health-care industry, and that as a result, employee morale was low and employment turnover high." Accordingly, "Congress determined that the extension of organizational and collective-bargaining rights

would ameliorate these conditions and elevate the standard of patient care." *Id.* at 497-98.

Unfortunately, as we have shown above, poor working conditions still exist in today's nursing homes. Decisions like that of the Court of Appeals in this case stand as an obstacle to the attainment of Congress' objective to "ameliorate these conditions and elevate the standard of patient care." *Id.*

CONCLUSION

This Court should reverse the decision of the Court of Appeals and affirm the Board's reasonable construction of the Act to protect the nurses at issue.

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